

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-018297

4628

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

FILED MAY 2 1963

1- PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St Louis, Mo.

Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION **1243 Bayard St.**

Inside Limits
Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

admission)

c. CITY
OR
TOWN **St. Louis**

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location)
1243 Bayard St.

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

H erbert Taylor

Last

4. DATE
OF
DEATH

Month

Day

Year

April 25 1963

5. SEX
Male

6. COLOR OR RACE
Negro

7. Married ☒ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)
Postmaster

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state of country)
Nymph Ala.

12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

Daniel Taylor

13b. MOTHER'S MAIDEN NAME

Millie Moye

14. NAME OF HUSBAND OR WIFE

Arlethia Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
29

17. INFORMANT

Address

Arlethia Taylor 1243 Bayard

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **September 1962** to **April 20th** and last saw him alive on **April 25th**
Death occurred at **1:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

Burial

5-1-63

National Cemetery

Jefferson Barracks Mo

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

A. L. Beal Und Co 4303 Delmar

APR 27 1963

Neal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arthur L. Heubrich

Licensed Embalmer No. 4221

P. O. Address 3100 Canton Ave

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.